EXHIBIT G

STATEMENT

ABBAS KASHANI, M.D.
P.O. BOX 500
BAYCHESTER STATION
BRONX, NY 10469
Tel: 914/654-6543

Tax I.D. 060686325

STATEMENT DATE
10/06/07

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ACCOUNT NUMBER
7200831431 - 1 / SP

Patient: SALEH, OSAMA

INDICATE AMOUNT PAID $_____

Saleh, Osama
1-256 7233 67th St Apt 3L
Glendale NY 11385-6923

Detach and Return With Payment

*PLACE CODES 1. OFFICE 2. IN-PATIENT HOSP. 3. OUT-PATIENT HOSP 4. EMERGENCY ROOM 5. CLINIC

To assure proper credit detach the top portion and return with your remittance and/or see reverse side for instructions.

DATE	ICD9 CODE	*PLACE CODES	DESCRIPTION	AMOUNT
			Balance forward last statement	0.00
09/17/07	AK	OH	99203 INITIAL OFFICE/OUTPATIEN	150.00

CURRENT AMOUNT	PAST DUE AMOUNT	REFERRING PHYSICIAN	PLEASE PAY THIS AMOUNT	
150.00	0.00	KASHANI, ABBAS MD	▶	150.00

PLEASE REMIT PAYMENT DUE

ANY QUESTIONS PLEASE CALL 914/654-6543 EXT 114.

NOTE: PAYMENTS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

STATEMENT

'YCKOFF EMERGENCY MEDICINE SERVICES Tax I.D. 113495935
.O. BOX 500
AYCHESTER STATION
RONX, NY 10469
el: 914/654-6543

STATEMENT DATE
10/06/07

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1

ACCOUNT NUMBER
8300831431 - 1 / SP

Patient: SALEH, OSAMA

INDICATE
AMOUNT PAID $_____

Saleh, Osama
3-729 7233 67th St Apt 3L
Glendale NY 11385-6923

Detach and Return With Payment

PLACE CODES 1. OFFICE 2. IN-PATIENT HOSP. 3. OUT-PATIENT HOSP 4. EMERGENCY ROOM 5. CLINIC

To assure proper credit detach the top portion and return with your remittence and/or see reverse side for instructions.

DATE	ICD9 CODE	*PLACE CODES	DESCRIPTION	AMOUNT
			Balance forward last statement	0.00
09/06/07	Q7	ER	99284 E/R VISIT-HIGH SEVERITY	330.00

CURRENT AMOUNT	PAST DUE AMOUNT	REFERRING PHYSICIAN	PLEASE PAY THIS AMOUNT	
330.00	0.00	KATARI, NAGENB MD		330.00

PLEASE REMIT PAYMENT DUE

ANY QUESTIONS PLEASE CALL 914/654-6543 EXT 123.

NOTE: PAYMENTS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

WYCKOFF IMAGING SVCS, PC
PO BOX 435
Lititz PA 17543

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
11/13/2007	520.00	1131038

SHOW AMOUNT PAID HERE $

ADDRESSEE

REMIT TO:

OSAMA SALEH
7233 67TH ST
APT 3L
GLENDALE NY 11385

WYCKOFF IMAGING SVCS, PC
PO BOX 435
Lititz PA 17543

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Patient Name	Insurance Balance	Patient Balance	Statement Date	Page
OSAMA SALEH	0.00	520.00	11/13/2007	1/1

Service Date	Bill Number	Provider Name	Total Charge	Payments Adjustments	Insurance Balance	Patient Balance
09/07/2007	3151550	Anjana Patel	215.00	0.00	0.00	215.00
09/06/2007	3151551	Jeffrey Fischbein	305.00	0.00	0.00	305.00

Total Charges:	520.00
Amount Paid by Insurance:	0.00
Amount Due from Insurance:	0.00
Please Pay This Amount:	***520.00***

Current	30-60 Days	61-90 Days	91-120 Days	120+ Days	Total Balance	Insurance Due	Patient Due
0.00	520.00	0.00	0.00	0.00	520.00	0.00	520.00

Please be advised that the Patient Balance above is now your responsibility

Kindly make your check payable to WYCKOFF IMAGING SVCS, PC and mail to the above address.

Si necesita ayude en espanol Por Favor llame al: (800) 605-1483

SERVICES WERE RENDERED AT:

Billing Questions: (800) 605-1483

WYCKOFF HEIGHTS MEDICAL CENTER

Office Hours: Monday - Friday 8:00 AM - 5:00 PM

1155

STATEMENT

WYCKOFF ANESTHESIA MEDICAL SERVICES,
P.O. BOX 500
BAYCHESTER STATION
BRONX, NY 10469
Tel: 914/654-6543

Tax I.D. 113519417

STATEMENT DATE
10/06/07

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1

ACCOUNT NUMBER
1600831431 - 1 / SP

Patient: SALEH, OSAMA

INDICATE
AMOUNT PAID $_____

Saleh, Osama
1-119 7233 67th St Apt 3L
Glendale NY 11385-6923

Detach and Return With Payment

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DATE	ICD9 CODE	*PLACE CODES	DESCRIPTION	AMOUNT
			Balance forward last statement	0.00
09/10/07	MT	IH	21356 OPEN TREAT ZYGOMATIC FX	675.00
09/21/07	PLEASE PROVIDE INSURANCE INFORMATION			
09/21/07	THIS BILL IS YOUR RESPONSIBILITY			
09/21/07	PLEASE CALL 914/654-6543 EXT 119 THANKYOU			

CURRENT AMOUNT	PAST DUE AMOUNT	REFERRING PHYSICIAN	PLEASE PAY THIS AMOUNT	
675.00	0.00	MYINT, SOE MD		675.00

PLEASE REMIT PAYMENT DUE

ANY QUESTIONS PLEASE CALL 914/654-6543 EXT 123.

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